Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HANGER PROSTHETICS AND ORTHOTICS

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-16-0899-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
DECEMBER 07, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In regards to this claim we were precise on submitting the documentation to prove medical necessity in which we did receive an authorization. We were consistent on our follow up calls to check claim status and appeals for the three procedure codes that were not paid on this claim. I am aware that there is no guarantee of payment, however we were working in good faith for our patient and you're insurant to provide a prosthesis that will allow this young man to continue working and endure his everyday activities of daily living."

Amount in Dispute: $116,380.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the DWC-60 and other documentation, the Requestor is seeking reimbursement for services rendered March 20, 2014. The Requestor billed $139,012.00 for medical treatment and the Respondent paid $20,007.41 (not $0 as stated by Requestor on the DWC-60). The Requestor is now seeking reimbursement in the amount $116,380.00…At the outset it should be noted that this Medical Fee Dispute Resolution Request was not timely submitted in regard to this date of service."

Response Submitted by: White Espey, PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2014	HCPCS Code L5999-RT Lower Extremity Prosthesis, Not Otherwise Specified	$1,186.00	$0.00
	HCPCS Code L8499-RT Unlisted Procedure For Miscellaneous Prosthetic Services	$194.00	$0.00
	HCPCS Code L5999-RT Lower Extremity Prosthesis, Not Otherwise Specified	$115,000.00	$0.00
TOTAL		$116,380.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 106-Provide invoice showing cost for reimbursement.
   - 16-Not all info needed for adjudication was supplied.
   - 352-Network disc not applicable to procedure billed.
   - W3-Appeal/Reconsideration.

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is March 20, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on December 7, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/30/2015 Date
Signature	Health Care Business Management, Executive Deputy Commissioner	12/30/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.